Personal Representative/Personal Care Representative Designation

Recipient's Name:_____

SSN: _____Medicaid/Nevada Check Up #: _____

I hereby designate the following individual as my (check as appropriate – one or both):

☐ **Personal Representative** ☐ **Personal Care Representative**

_____

(Print Name)

And as such, I allow and authorize the Nevada Department of Human Resources, Division of Health Care Financing and Policy (DHCFP) ("Medicaid or Nevada Check-Up") to disclose my personal health information that is protected by federal privacy regulations in accordance with the following:

Personal Representative - All information held in a designated record set by DHCFP or their business associates. I further authorize my personal representative, named above, to represent me and my interests with DHCFP. As my personal representative, the above named person has the same rights to access, inspect, obtain a copy, request restrictions on disclosures, request amendments or corrections, request an accounting of disclosures, and request alternative means or location of communications as I have as the subject of the personal protected health information.

Personal Care Representative – Only that information held in a designated record set by DHCFP or their business associates relevant to their involvement in my immediate care as delineated in the attached document.

I understand that federal privacy regulations do not apply to the individual I have designated as my personal representative or personal care representative and that protected health information disclosed to this individual may be subject to further disclosure without my explicit authorization.

This Authorization is valid and in effect until I provide written notice to DHCFP that I no longer wish this individual to represent me.

I release the Nevada Department of Human Resources, Division of Health Care Financing and Policy from any liability resulting from authorized disclosure of information to my personal representative or personal care representative. A copy of this Authorization can serve as an original.

_____ _____

Signature of Recipient Date

State Worker Witnessing Signature _____